DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445242	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE HEALTH CARE CENTER	181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure all areas have the proper air flow. The Findings Include: Observation on July 19, 2011 between 10:00 a.m. and 3:00 p.m. revealed the following areas have no positive air flow, For Example Only; Entrance foyer, First floor unit Cordinator office and First floor 100 hall. Observation on July 19, 2011 between 10:00 a.m. and 3:00 p.m. revealed the following areas have no negative air flow, For Example Only; Beauty shop, Family room, First floor 100 hall.	K 067	In order to address air flow in the unit coordinators office, a two zone HVAC unit will be installed with air supply directed to that office. A three-speed exhaust fan will be installed in the beauty shop. New duct work will be added from the Administrative Hall HVAC unit to the Family Room and the entrance foyer to increase air return in those areas. Return visit from Office of Health Care Facilities on September 21st will determine if further action is required including testing and balancing.	9/21/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X8) DATE: 9/8/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.